REPORT TO THE LEGISLATURE

JLARC MENTAL HEALTH SYSTEM PERFORMANCE AUDIT

Status Report

RCW 71.24.820

Department of Social and Health Services
Health and Rehabilitative Services Administration
Timothy R. Brown, Assistant Secretary

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EXECUTIVE SUMMARY

This report fulfills the requirements of RCW 71.24.820. The law requires the Department of Social and Health Services (DSHS) to submit a report to the legislature on the status of implementation of the recommendations made in the Joint Legislative Audit and Review Committee (JLARC) Performance Audit of the Mental Health System. The specific language is as follows:

> "In addition to any follow-up requirements prescribed by the joint legislative audit and review committee, the department of social and health services shall submit reports to the legislature on the status of the implementation of recommendations 1 through 10 and 12 through 14 of the performance audit report. The implementation status reports must be submitted to appropriate policy and fiscal committees of the legislature by June 1, 2001, and each year thereafter through 2004.

The 1999 JLARC performance audit made 14 recommendations for improved management of the mental health system. The recommendations were in the areas of coordination of services, fiscal accountability, and moving towards an outcome-based system. The department last reported to the legislature in June 2002 and to the JLARC committee in December 2002. This status report updates both reports completed in 2002. Since that time, major changes/accomplishments are as follows:

⇒ The Mental Health Division (MHD), in coordination with Regional Support Networks (RSN) and the Aging and Disability Services Administration (ADSA), has accomplished the transfer of long term patients with significant barriers to discharge from the state hospitals to the community under the Expanding Community Services (ECS) initiative. As a result of these transitions, the state hospitals have been able to reduce their capacity by 178 beds. (Recommendation 3)

⇒ The MHD has made continued progress in streamlining and reducing process-oriented accountability activities by implementing the deeming process. In fulfillment of the Centers for Medicare and Medicaid Services' (CMS) expectations regarding deeming as a delegation of quality management responsibilities, MHD conducted a one percent case record review in lieu of a full licensing review on four Joint Commission for the Accreditation of Healthcare Organizations (JCAHO)-deemed providers during Fiscal Year 2002. The average score of these deemed agencies was 98 percent versus under 90 percent for the remaining agencies reviewed during the same cycle. (Recommendation 4)

⇒ The Balanced Budget Act (BBA) must be completely implemented by August 13, 2003. The BBA imposes several new regulations on managed care systems. The requirements are primarily administrative and process oriented. The final piece, 42 Code of Federal Regulations 438.300 requiring External Quality Review organizations validation of compliance, quality and performance, will be effective March 25, 2004.

The following pages summarize accomplishments, plans and obstacles under each recommendation. The JLARC report continues to be helpful in development of the mental health system.

IF THERE IS NO CHANGE SINCE THE DECEMBER 2002 STATUS REPORT, THE ACCOMPLISHMENTS, PLANS AND OBSTACLES ARE SHADED.

1. Coordinate allied services provided to mental health clients and implement strategies for resolving organizational, regulatory and funding issues at all levels of the system. **Agency Position:** **Concur**	**Accomplishments** • MHD collaboration with allied systems • MHD research projects with allied systems • MHD collaboration with the Division of Developmental Disabilities • MHD- JRA coordination activities • A-Team start ups • Secretary's Select Committee on hard to place adolescents • Real Choices Systems Change Grant • Family and Children's Services Integration Initiative
	Plan • Continued promotion of the 'A Team' concept • Performance indicator/ outcome system • ADSA-MHD-MAA Clinical pharmacy residency & fellowship • Real Choice Project implementation • Best practice models
	Obstacles • Resources for populations with special needs

ACCOMPLISHMENTS

- **MHD collaboration with allied systems:** MHD, ADSA, Division of Alcohol and Substance Abuse (DASA) and the Medical Assistance Administration (MAA) are collaborating on the Washington Medicaid Integration Project (WMIP) to coordinate care and braid funding for Medicaid or dual eligible clients receiving services from one or more of these programs. Discussions are under way to determine a site for a pilot project covering 4,000 or more clients. MHD is also collaborating with MAA, DASA and ADSA on a Disease Management project. The project is identifying shared clients whose chronic medical condition (Asthma/COPD, Diabetes, Congestive Heart Disease, End Stage Renal Disease) is complicated by a co-morbid condition such as mental illness or substance abuse. If eligible for the project, clients volunteer to have access to an RN who helps them (and their case managers) manage their chronic illnesses. Each RSN has a point of contact facilitating this coordination.

- **MHD research projects with allied systems:** MHD and DASA are involved in a study of mental health services, substance abuse services and Medicaid payments to look at service delivery and cost patterns. MHD and DASA have completed a retrospective study following individuals who were discharged from the state hospitals in 1996. MHD is also participating in the Medicaid Integration Project evaluation with other DSHS divisions. Other collaborations include training for case managers on co-occurring disorders in youth and adults, and several collaborative grant applications for treatment of individuals with co-occurring disorders. Studies are intended to identify best care practices for multiple need clients. MHD will use the results studies as part of designing an incentive program for RSNs.

- **MHD collaboration with the Division of Developmental Disabilities (DDD):** The DDD/MHD Collaborative Work Plan was an effort developed in 1999 between the MHD and DDD in response to concerns voiced by the Washington Protection and Advocacy System (WPAS) about individuals with developmental disabilities and co-occurring mental illness, mental disorders, and/or challenging behaviors. The Collaborative Work Plan became the mediated settlement agreement for *"Allen"* v WSH et al". This plan called for three separate and distinct areas of development: 1) improving services at the state hospitals; 2) developing an array of appropriate, cost-effective diversionary services to prevent unnecessary state hospitalization; and 3) the development of secure long-term treatment facilities for DDD enrolled individuals who pose a risk to public safety. In the past six months, combined efforts of MHD and DDD have successfully diverted 108 admissions to the state hospitals using 1,377 diversion bed days, have provided 1,125 individuals with 9,619 hours of crisis prevention and intervention services, and have provided 649 individuals with psychiatric evaluation and medication services. The average admissions per month have been reduced.

- **MHD-JRA coordination activities:** The MHD and the RSNs collaborated with the Juvenile Rehabilitation Administration (JRA) to create a referral protocol that enables identified JRA clients with mental health issues transitioning into the community to receive assessment and medical appointments with the RSNs upon release. JRA gives the RSN the clinical information on each client. This enables the RSNs to get a 'jump start' on planning for services and provides the basis for ongoing collaboration with the parole officers and families of the clients. All 14 RSN's have signed Transition Protocol Agreements with JRA. As of April 2003, there have been approximately 115 referrals as a result of the Transition Protocol Agreements.

- **A-Team start-ups:** MHD and ADSA continue to work together to promote the use of the 'A-Team concept', a Snohomish County based best practice effort, in all regions. This concept creates a team of cross system partners to staff challenging multi-need cases. The cross system staffing has resulted in a reduction in inpatient hospitalization and a reduction in the use of emergency services. A-Teams have been replicated and are operational in Pierce, Chelan, Clark, King, Skagit, and Benton-Franklin Counties.

- **Secretary's select committee on hard to place adolescents:** MHD incorporated into the RSN contract a recommendation from the Committee that mental health treatment interventions be research-based and shown effective in achieving positive outcomes.

- **Real Choices Systems Change Grant:** In July 2001, MHD, ADSA, and DDD submitted a proposal to Centers for Medicare and Medicaid Services (CMS) for a Real Choices Systems Change grant. The focus of the proposal is on removing systemic barriers to service for clients who have multiple needs and promoting the transition from institutional to community settings. In October 2002, DSHS was awarded a grant by CMS of $1.4 million.

- **Family and Children's Services Integration Initiative:** MHD is participating with the Children's Administration (CA) on the new Family and Children's Services Integration Initiative which will improve integration and coordination between administrations and with our community partners in the design of a new integrated service delivery model.

PLAN

- **Continued promotion of the 'A Team' concept:** MHD and ADSA will continue to monitor progress of existing A-Teams and encourage the replication of A-Teams in other counties.

- **Performance indicator/outcome system:** When the performance indicator/outcome system is in place, client outcomes will be used to evaluate the value/success of collaborative efforts. MHD is working with the DSHS Division of Research and Data Analysis (RDA) to identify cross-system performance indicators. (See Recommendations 9 and 10)

- **ADSA-MHD-MAA clinical pharmacy residency & fellowship:** ADSA, MHD, and MAA are collaborating on an advanced practice clinical pharmacy residency and fellowship in geriatric medicine in Eastern and Western Washington. The residency programs will emphasize continuity of psychiatric care for elderly individuals being discharged from state and community psychiatric hospitals. The residency programs are being established as pilot projects and will be evaluated to determine their effect on community and state hospital utilization. Residents will work with frail elderly persons who are home bound or residing in long-term care settings.

- **Real Choice Project implementation:** MHD and ADSA have filled two positions to implement objectives of the Real Choice Grant. This project will focus on developing systemic improvements toward the transition of individuals in state psychiatric hospitals into community settings as well as the prevention of unnecessary hospitalization for individuals in the community with multiple disabilities.

- **Best practice models:** MHD and the Office of the Superintendent of Public Instruction (OSPI) Special Education Division are developing an agreement that will facilitate increased collaboration between the RSNs and local school districts to improve services for special education students needing mental health services. Best practice models are being identified.

OBSTACLES

- **Resources for populations with special needs:** The lack of community resources for individuals with behavioral issues related to organic brain disorders such as dementia, traumatic brain injury, fetal alcohol syndrome and autism is a challenge. These clients are often involved in multiple systems such as state hospitals and community geriatric care facilities.

2. Require RSNs to collaborate and work with allied service provider agencies in providing mental health services and identify RSN responsibilities to achieve collaboration. MHD should enforce the provisions of those contracts. **Agency Position:** **Concur**	**Accomplishments** • RSN contract terms • MHD-CA coordination activities • RSN baseline information
	Plan • Enforce contract terms
	Obstacles • Increased administrative burden

ACCOMPLISHMENTS

- **RSN contract terms:** MHD included contract language related to coordination of services in the 2001-03 RSN contract. RSNs are required to develop service delivery protocols for children including, but not limited to, Native American/Indian children and children served by JRA and CA and adults served by ADSA. MHD has made incentive money available to assist with the development of these protocols. The 2003-05 contract requires the RSNs to submit their completed service delivery protocols developed under the 2001-03 contract and to implement the protocols. There are no incentives offered in the 2003-05 contract. The 2003-05 contract also contains the Secretary's Select Committee term for service delivery expectations for children and youth. In addition, there is a term requiring continued collaborative work with cross-system partners and a term that requires implementation of MHD directives if cross-system barriers cannot be resolved at the local area.

- **MHD-CA coordination activities:** MHD and CA are in the process of finalizing a matrix to improve interagency collaboration. The RSNs and CA regions are developing service delivery protocols for improved coordination and integration of services as part of the MHD contract. The protocols are due in October 2003.

- **RSN baseline information:** RSNs have submitted baseline information on coordination with the CA and ADSA.

PLAN

- **Enforce contract terms:** Contract language gives MHD a range of options for enforcement including corrective action, modification of RSN policies, denial of incentive payments and withholding of a portion of the monthly capitation payment pending resolution of issues.

OBSTACLES

- **Increased administrative burden:** RSNs have noted the increased administrative burden related to writing plans and producing reports on collaborative service delivery.

3. MHD, ADSA, state hospitals, and RSNs should ensure hospital discharge and community placement for eligible clients occur in a timely manner. **Agency Position:** **Concur**	**Accomplishments** • Inpatient/residential study • Completion of ECS Project • RSN contract
	Plan • ECS evaluation
	Obstacles • Decrease in community psychiatric inpatient capacity • Insurance for providers and hospitals

ACCOMPLISHMENTS

- **Inpatient/residential study:** MHD contracted with the Public Consulting Group (PCG) to assess inpatient and residential resources in Washington State. In September 2002, PCG produced a report entitled "Projecting the Need for Inpatient and Residential Behavioral Health Services for Adults Served by the Mental Health Division." The report concluded that inpatient and residential resources are lacking in the state of Washington as compared to eight peer states, leading to reliance on the state hospitals and other inpatient systems of care. In order to prevent further reliance on expensive inpatient resources, the report recommended investments in residential and intensive outpatient programs.

- **Completion of Expanding Community Services:** DSHS has completed the ECS project to address the issues of timeliness of discharge, coordinated service planning and adequate community resources. The project has transitioned 120 long term patients in the state hospitals with barriers to placement who are now being served more appropriately in community settings.
  - ⇒ **December 2001 and October 2002 ward closures** - An unforeseen event that affected the ECS initiative was the February 2001 earthquake in Western Washington. The earthquake damaged buildings and reduced capacity at Western State Hospital (WSH). To maintain the reduced capacity, RSNs made extraordinary efforts to develop alternative placements and diversions for patients and individuals that would otherwise have been served at WSH. As a result of these efforts, there were no additional transitions required to accomplish the December 2001 and October 2002 ward closures. The workforce at WSH was reduced and ECS funds were provided to the communities in order to maintain their ability to support individuals in local settings.
  - ⇒ **Housing preferences survey -** A consumer housing preferences survey was completed at WSH to determine the support needs and housing preferences of individuals to be transitioned through the ECS program. The results were shared with treatment coordinators and administrators to assist in planning for the housing and residential needs of these individuals in the community.

⇒ **July 2002 ward closure –** Thirty long-term adult patients at WSH with significant barriers to placement were transitioned back to their communities by RSNs in June and July 2002. The majority of these individuals remain in the community and are doing well. Two individuals have returned to WSH, and the RSNs have transitioned alternate patients into the community slots developed for these individuals. Two individuals have passed away since their discharge into the community. As a result of the transitions, a ward serving older adults at WSH was closed in July 2002. The hospital workforce was reduced to reflect these changes.

⇒ **December 2002 ward closure** – Thirty long-term patients from the gero-psychiatric wards at ESH were transitioned back to community settings in November and December 2002. These individuals were either older adults or adults with significant medical and behavioral issues. ADSA took the lead in developing the resources for these individuals in close coordination with the RSNs. The majority of these individuals remain in the community and are doing well. One has returned to ESH, and ADSA has transitioned an alternate patient into the community slot developed for this individual. One individual died from a heart attack following discharge into the community. As a result of the transitions, a ward serving older adults at ESH was closed in December 2002. The workforce was reduced to reflect these changes.

⇒ **January 2003 ward closure** – Thirty long-term adult residents with significant barriers to placement from the Program for Adaptive Living Skills (PALS) on the grounds at WSH were transitioned back to the community by RSNs in December 2002. These individuals remain in the community and are doing well. As a result of the transitions, 30 beds at the PALS program were closed in January 2003. The program workforce was reduced to reflect these changes.

⇒ **April 2003 ward closure –** Thirty long term patients from the gero-medical wards at WSH were transitioned back to community settings in March and April 2003. These individuals were either older adults or adults with significant medical and behavioral issues. ADSA took the lead in developing the resources for these individuals in close coordination with RSNs. These individuals remain in the community and are doing well. As a result of the transitions, a ward serving older adults at WSH was closed in April 2003 and the workforce was reduced to reflect these changes.

⇒ **Front door capacity** – In order to maintain the decreased capacity at the state hospitals, MHD and ADSA have coordinated to create enhanced services to maintain approximately 70 older adults or adults with significant medical and behavioral disorders who are at risk of hospitalization in their communities.

- **RSN contract:** The proposed 2003-05 RSN contract requires the RSNs to develop a written agreement with the state hospitals to address key discharge issues including: inter-RSN transfer of consumers being discharged from the hospital; collaborative patient discharge planning and coordination with appropriate cross-system partners; and identification and resolution of the barriers to discharge of individual long-term patients, systemic issues that create delays or prevent placements in the contractor's service area. The contract also provides for the implementation of liquidated damages – to be assessed at the state hospital bed day rate after hospital determination that a consumer is ready for discharge – if the written agreements do not result in improved timely discharges.

PLAN

- **ECS evaluation:** An evaluation involving MHD, DASA, ADSA and MAA is collecting data on individuals who returned to the community after discharge from WSH and ESH through the ECS program. Outcomes being evaluated include:
  - ⇒ Provision of services in the least restrictive setting possible
  - ⇒ Prevention of unnecessary or lengthy hospitalizations
  - ⇒ Increase of community support/transition services
  - ⇒ Improved quality of life for consumers
  - ⇒ Cost savings to DSHS
  - ⇒ Improved placement and diversion alternatives

OBSTACLES

- **Decrease in community psychiatric inpatient capacity:** A decrease in bed capacity for community psychiatric inpatient care in Washington State and border counties of Idaho and Oregon provides challenges to maintaining bed reductions at the state hospitals.

- **Insurance for providers and hospitals** – Community residential providers and community hospitals are reporting difficulty maintaining adequate insurance coverage. Providers are experiencing large increases in insurance rates or, in some cases, complete cancellation of insurance. Providers in the ECS program are being affected. This issue has the potential to jeopardize the long-term success of the program.

4. Streamline and reduce process-oriented accountability activities. Negotiate with HCFA regarding how to replace process-oriented system accountability requirements with system and client outcomes reporting. **Agency position:** **Partially concur**	**Accomplishments** • Reduce audit duplication • Implement deeming of licensed providers
	Plan • Meeting with the Centers for Medicare and Medicaid Services (CMS) • Process to data work group • Licensing
	Obstacles • Balanced Budget Act

ACCOMPLISHMENTS

- **Reduce audit duplication:** Some RSNs are using MHD's client record review tool to oversee the quality of provider documentation. Such usage allows MHD to enter the shared data into the MHD audit database and to streamline audits.

- **Implement deeming of licensed providers:** MHD has successfully implemented deeming. A memorandum of understanding with the Council for Accreditation of Rehabilitation Facilities (CARF) was finalized on January 8, 2002. A memorandum of understanding with the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) was finalized on January 17, 2002. Currently, 33 agencies are participating in the deeming process. Approximately 26 percent of the mental health provider agencies in Washington State will be eligible for deeming.

PLAN

- **Meeting with CMS (formerly HCFA):** MHD met with CMS on July 18, 2001 regarding this recommendation. CMS staff were supportive of MHD plans for a consumer outcome system and agreed to further discussions once outcomes are available. Since that visit, there has been a change in Region X leadership. A follow-up meeting is planned in Fall 2003, after the 2003-05 RSN contracts are initiated reflecting less reliance on process monitoring and more on outcomes data.

- **Process to Data work group:** MHD established a workgroup (the Development Team) charged with the task of leading and coordinating the development of contract and waiver language. A major effort was made to identify and eliminate processes. Stakeholders, including RSNs and providers participated. Recently, the Washington Community Mental Health Council newsletter recognized the division for its effort to replace process measures. The development team is now turning its attention to carry those same principles into the development of revised WAC.

- **Licensing:** Licensing reviews are expected to decrease in duration as a result of WAC changes that consolidate health and safety requirements.

OBSTACLES

- **Balanced Budget Act (BBA):** CMS is moving toward *more* process-oriented accountability in the BBA. The BBA has several new managed care regulations related to notifications to enrollees, advance directives, grievance procedures, quality strategies, screening, assessment and credentialing. Note: Since the June 2001 status report, implementation of the BBA has been delayed by the federal government for one year to July 2003. While this is helpful for planning purposes, MHD still expects this legislation to have significant impact at all levels of the mental health system. The waiver amendment and contract are mostly complete and BBA compatible.

5. The legislature should clarify its intent that the system be "efficient and effective" by amending RCW 71.24.015. **Agency position:** **Concur**	The legislature accomplished this in Chapter 334, Laws of 2001 (ESSB 5583a).

6.1 Reduce the number of reported cost elements to those directly linked to the accountability process. **Agency position:** **Partially concur**	**Accomplishments** • 2000 reporting instructions document decreased reportable elements
	Plan • Link cost elements to the performance indicator/outcome system
	Obstacles • Other information requests

ACCOMPLISHMENTS

- **2000 reporting instructions document decreased reportable elements:** In the 2000 reporting instructions document for RSNs, three reported cost element codes were combined to create outpatient treatment. Two reported cost element codes were combined to create utilization management and quality assurance. One code was eliminated.

PLAN

- **Link cost elements to the performance indicator/outcome system:** Once the performance indicator/outcome system is complete, cost information collected will be reassessed to ensure linkage to the accountability process.

OBSTACLES

- **Other information requests:** Some cost elements may need to be collected that are not part of the accountability process. These cost elements identify how much RSNs spend on certain activities, such as Evaluation and Treatment Centers, residential and employment. MHD uses the information for research projects, to complete grant applications and to respond to requests for information from legislators and persons interested in specific programs.

6.2 Clarify the definition of "provider administration" to improve consistency in reporting. **Agency position:** **Concur**	**Accomplishments** • Defined in 2000 reporting instructions document **Plan** • Consistency of reporting **Obstacles** • Variation among providers

ACCOMPLISHMENTS

- **Defined in 2000 reporting instructions document:** Provider administration was defined and separated from RSN administration in the 2000 reporting instructions document. The definition included costs allowable for administration.

PLAN

- **Consistency of reporting:** MHD continues to promote uniform information/accounting data systems that would enable the RSNs and their providers to capture information in a more consistent and accountable manner. Systems that allow the breakdown of information by business functions would enable the RSNs, providers, and MHD to make better decisions regarding cost reduction and could, in turn, develop more efficient ways to conduct business.

OBSTACLES

- **Variation among providers:** As more detail is reviewed and more provider staff interviewed, issues become technically complex. Before changes are made, additional research is needed to avoid administrative burden and inconsistency.

6.3 Instruct RSNs to report cost information so it reconciles with county-maintained RSN records. **Agency position:** **Concur**	**Accomplishments** • FY01 and FY02 instructions clarified required information • FY03 instructions clarified **Plan** • Continuing research to improve consistency **Obstacles** • None noted

ACCOMPLISHMENTS

- **FY01 and FY02 instructions clarified required information:** FY 01 was the first year that MHD asked providers to report only the expenditures of funds originating from MHD. This was not fully successful and MHD engaged the RSNs in a discussion of the issues. In FY02, specific instructions clarified providers' reporting requirements.

- **FY 03 instructions clarified:** MHD continues to work with the RSNs in fine tuning the instructions and reporting of information on an annual basis. This includes:
    - Validating that direct serve costs are not being impacted by the percentage of revenue reduction;
    - Reconciling reserves – requesting RSNs to validate any variances; and
    - Verifying PHP revenues against MHD's payment records

PLAN

- **Continuing research to improve consistency:** MHD fiscal staff will continue to identify what is unclear and to identify other factors that impede consistency.

6.4 Collaborate with State Auditor's Office to ensure RSNs segregate revenues, fund balances and reserves from other county funds. **Agency position:** **Partially concur**	**Accomplishments** • Met with State Auditor September 26, 2001 **Plan** • No further action planned at this time **Obstacles**

- **Discussion with State Auditor:** The auditor's office viewed this issue as more county than RSN related. Auditor's office staff did state that they intend to contact Sterling and Associates to clarify intent. No further action planned at this time.

6.5 Explore the feasibility of Local Government Financial Reporting System to assist MHD with monitoring and streamlining the cost reporting process. **Agency position:** **Partially concur**	**Accomplishments** • Met with the State Auditor September 26, 2001 **Plan** • No further action planned at this time. **Obstacles**

- **Discussion with State Auditor:** The auditor's office does not think it would be helpful for MHD to go to this level for information. However, as noted above, they will contact Sterling and Associates regarding these recommendations. No further action planned at this time.

6.6 Develop a process to quantify and report costs of RSN utilization of state hospitals and integrate with other RSN cost information. **Agency position:** **Concur**	**Accomplishments** • Completed - Reporting process in place **Plan** • N/A **Obstacles**

ACCOMPLISHMENTS

- **Reporting process:** Reporting will be consistent with the Revenue and Expenditure reports issued twice a year. Method of including RSN utilization of state hospitals will be the same as the method JLARC used. Reporting begins with the June 2001 revenue and expenditure report.

7.1 The definition of direct services should be narrowed to include only those expenditures directly related to client services. **Agency position:** **Concur**	**Accomplishments** • FY01 reporting instructions narrowed this definition **Plan** • N/A **Obstacles**

ACCOMPLISHMENTS

- **FY 01 reporting instructions:** This reporting instructions document removed the following elements from the definition of direct service: patient tracking system, utilization management, quality assurance and public education.

7.2 Create a new expenditure category to include direct services support. Expenditures. **Agency position:** **Concur**	**Accomplishments** • Completed in FY01 reporting instructions **Plan** • N/A **Obstacles**

ACCOMPLISHMENTS

- **FY01 reporting instructions:** The new expenditure category was created in July 2000. The category includes four types of costs and definitions for each.

7.3 Include in the fiscal accountability standard the reporting of administrative and support costs of MHD, state hospitals and community hospitals. **Agency position:** **Partially concur**	**Accomplishments** • Completed in FY01 reporting instructions **Plan** • N/A **Obstacles**

ACCOMPLISHMENTS

- **FY01 reporting instructions:** This can be reported on a statewide basis as part of the Revenue and Expenditure reports issued twice a year. The method of including these costs will be the same as the method JLARC used. Reporting began with data as of June 2001. Based on this method, MHD completed an estimate of administrative, direct service and direct services support for FY01.

8. MHD should develop uniform client and client service data definitions to address the inconsistencies noted in this report. **Agency position:** **Concur**	**Accomplishments** • Data dictionary revision • Monthly data quality reports • Provider website **Plan** • Monitoring **Obstacles** • HIPAA implementation

ACCOMPLISHMENTS

- **Data dictionary revision:** The data dictionary, MHD's published manual of data elements and definitions, has been reviewed and revised in meetings with RSNs, providers and consumers. Service definitions have been revised to increase reporting consistency and assure compliance with the Health Insurance Portability and Accountability Act (HIPAA). Data dictionary revisions were included in the 2001-03 RSN contract. MHD developed a "Frequently Asked Questions" document that clarifies additional data reporting questions. MHD also contracted with the Washington Institute for Mental Illness Research and Training to develop field-training protocols to instruct RSN and provider staff. The protocols have been incorporated into a public website for service providers.

- **Monthly data quality reports:** MHD has developed data quality reports which are distributed monthly to RSN staff.

- **Provider website:** A public website has been developed that providers and clinicians can access. The website lists all data elements reported by providers, data definitions and codes. It provides training on rating scales, lists frequently asked questions and directs additional questions to MHD for response.

PLAN

- **Monitoring:** Monitor data for consistency

OBSTACLES

- **HIPAA implementation: C**hanges to MHD and RSN data systems are requiring considerable resources at all levels of the mental health system.

9. Use outcomes/implement a uniform performance measurement system required by RSN contracts. **Agency position:** **Concur**	**Accomplishments** • Performance indicators in 2001-03 contract • Benchmarks and goals • Data consistency **Plan** • Indicator report • Additional data collection **Obstacles**

ACCOMPLISHMENTS

- **Performance indicators in 2001-03 contract:** MHD incorporated twelve of the JLARC performance indicators into the 2001-03 RSN contracts, with plans to develop four more over the course of the contracts. The selection of the indicators was based on data sources currently available. This is not the comprehensive system envisioned by JLARC (See Recommendation 10).

  1. Penetration rates for services by race/ethnicity, age, gender and Medicaid eligibility
  2. Utilization rate for services by race/ethnicity, age, gender and priority population
  3. Recipient perception of access
  4. Recipient perception of quality/appropriateness of services
  5. Recipient perception of active participation in decision making regarding treatment
  6. Percentage of service recipients who are employed
  7. Average annual cost per recipient served
  8. Average annual cost per unit of service; cost per hour for community services
  9. Percent of revenues spent on direct services
  10. Percent of recipients who were homeless in the last 12 months by age and priority population
  11. Percent of children who live in "family-like" settings
  12. Percent of children and adolescents receiving services in natural settings outside of a clinician's office

  The following measures will be under development during this contract period and will be included in the contract. Data will be gathered and reported throughout the contract period to refine the indicators.

  1. Percent of recipients who are maintained in the community without a psychiatric hospitalization during the last 12 months
  2. Percent of recipients who receive services by both MHD and DASA in the previous 12 months
  3. Percent of consumers who access physical healthcare
  4. Percent of service recipients living in stable environments

  All 16 indicators are being reported in the Performance Indicator report being released in July 2003.

- **Benchmarks and goals:** An internal MHD workgroup has developed benchmarks and goals for the Performance Indicators.

- **Data consistency:** Ensuring report compliance and consistency was the focus of FY 01. Monthly reports are now generated and disseminated to RSNs to increase data consistency.

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- **Indicator report:** A Second Annual Performance Indicator Report has been developed, is being reviewed and will be available for distribution in July 2003. This report will contain the indicators listed above.

- **Additional data collection:** The division is working to develop data-sharing agreements with DOC and the Washington State Institute for Public Policy to provide the number of consumers who have arrest or other contact with the criminal justice system.

10. Implement an outcome-based performance measurement system consistent with the framework described in this report. **Agency position:** **Partially concur**	**Accomplishments** • Compliance/consistency of current data • Request for Proposals (RFP) completed and vendor selected • Piloting completed • HIPAA privacy rule clarified **Plan** • Comprehensive system development • Full RSN/provider participation **Obstacles** • Continued funding • Provider concerns • RSN concerns

ACCOMPLISHMENTS

- **Compliance/consistency of current data:** Employment, living situation and consumer perceptions of positive outcomes were reported in the first Performance Indicator report. As RSNs reviewed their data in comparison to others, many data changes and reporting changes occurred. Publishing this data has caused much more attention to be paid to the quality of this data, which in turn has improved the quality and consistency of the data.

- **RFP completed and vendor selected:** MHD completed the RFP process for the consumer outcome system. A vendor has been selected and the contract was implemented May 22, 2002.

- **Piloting completed**: System up and functional since February 2003. However, implementation delays have occurred. The real-time report generation feature was not completed until three months into the project. This, in conjunction with RSN concerns resulted in two pilot sites making the decision not to participate in the pilot. Four provider agencies are currently using the outcome system. Two more are receiving training with implementation in May and June 2003.

- **HIPAA privacy rule clarified:** Relationships between providers, RSNs, MHD and the vendor have been clarified to allow for transmission of protected health information. Purpose and use of data at each level have been clarified to meet HIPAA Privacy Standards.

PLAN

- **Comprehensive system development:** The development of a comprehensive consumer outcome system will take a minimum of three years. The following lists the steps and timelines for development of the consumer outcome system:

  1) Finalize contract with selected vendor. *Completed May 2002*
  2) Work with vendor to design implementation. *Completed September 2002*
  3) Data collection begins: Collect data on the Consumer Outcome Measure. Reports will be generated every 90 days to provide feedback on reporting quality and compliance to RSNs and providers. *December 2002-December 2003*
  4) Once reporting compliance meets standards of reliability, MHD will begin reporting these outcomes. RSNs will receive performance reports every 90 days, with annual reports generated for broader stakeholder groups. *January 2004*

5) Reports will be used by MHD to monitor contract compliance, to inform MHD strategic planning, and to implement an RSN incentive system that can be used to improve the quality and efficiency of mental health services.

- **Full RSN/provider participation:** The division will develop a plan within the next six months to begin full RSN/provider participation in the outcomes system.

OBSTACLES

- **Continued funding:** The JLARC report indicated that there will be continuing costs related to maintenance and revision of this system.

- **Provider concerns:** There have been objections raised by providers concerning the new system. Providers are concerned about clinical utility of data and perceived burden. The system has not been functioning long enough for providers to gain the benefit of change over time reporting.

- **RSN concerns:** RSNs have raised objections with the new system. They are concerned about MHD gathering this information, how it will be used, and what they will be held accountable for.

11a-c. Change the payment methodology to use the same allocation for federal and state outpatient funds; eliminate the distinction between inpatient and outpatient funding; reduce the disparity in rates per Medicaid eligible person **Agency position:** **Concur**	**Accomplishments** • Produced a proposal consistent with Chapter 71.24 RCW • Implementation began in September 2001 – phased in over six years. **Plan** **Obstacles**

11d. Allocate funding for state hospital beds to the RSNs **Agency position:** **Partially concur**	**Accomplishments** • Preliminary analysis • Current analysis **Plan** • Continuing technical assessment **Obstacles** • Federal funding streams; union contracts; state funding streams

ACCOMPLISHMENTS

- **Preliminary analysis:** MHD completed preliminary analyses in 1996 and 2000 and identified major issues.

- **Current analysis:** A report to the legislature on "RSN Administration of a Portion of Funds Appropriated to State Psychiatric Hospitals" was completed October 1, 2002. Despite the obstacles (identified below) to the full implementation of the "administer a portion" concept, the department believes it is engaged in a number of activities that support its intent. These include implementation of Expanded Community Services, activities to improve state hospital practices, the completion of an inpatient and residential study, development of outcome measures of re-hospitalization rates and outpatient follow-up care, and new RSN contract requirements related to hospital discharges.

PLAN

- **Continuing technical assessment:** MHD will continue to explore RSN responsibility for state hospital bed usage.

OBSTACLES

- **Federal funding streams; union contracts; state funding streams:** As found in earlier analyses of this recommendation, the October 1, 2002 report to the legislature indicates that the major issue is how to preserve federal funds which, at this time, are paid directly to hospitals that serve indigent persons. In addition to the risk of significant loss of federal funding to the state hospitals, there are also significant issues with union contracts and state hospital funding streams.

12. Conduct periodic studies of the estimated regional prevalence of mental illness. **Agency position:** **Partially concur**	**Accomplishments** • Stakeholder group formed, contractor hired • Agreed to modify PEMINS • Literature search on children's prevalence • Literature searches on other special populations • Expert panel formed • Prevalence estimates developed • Statistician hired
	Plan • Develop matrix of methods, populations and study costs • Key informant survey to estimate homeless numbers • Include children • Complete by due date
	Obstacles

ACCOMPLISHMENTS

- **Stakeholder group formed, contractor hired:** The stakeholder group includes consumers, family members, RSNs (King, Pierce, North Central, Timberlands), mental health providers, and The Washington Institute for Mental Illness Research and Training (WIMIRT). MHD has contracted with a coordinator for this study.

- **Agreed to modify PEMINS –** The stakeholder group agreed to use the previously completed PEMINS study and modify it to include under-represented groups including people in jails and institutions and homeless persons.

- **Literature search on children's prevalence**: Several stakeholders have expressed an interest in having children included in this study. A review of literature completed by WIMIRT shows wide variation in estimates of prevalence for children. Much of the variation can be explained by multiple definitions of mental illness in children.

- **Literature review for other special populations:** Literature reviews have been completed for jail and prison populations, nursing home populations, homeless individuals and refugees. Reviews are underway to find the best estimates of the number of these individuals in Washington State.

- **Expert panel formed and providing feedback:** Panel of national and state experts on mental health prevalence has been created. The panel is meeting with MHD staff and the stakeholder group to provide technical assistance to the current study.

- **Prevalence estimates for subgroups:** Prevalence estimates have been developed from existing literature for each special populations subgroup.

- **Statistician hired**: An expert in prevalence estimation has been contracted to produce prevalence estimates based on new census counts and the addition of subgroup prevalence estimates.

PLAN

- **Develop matrix of methods, populations and study costs:** The stakeholder group will use this matrix to guide the study. For example, the extent to which populations can be included will be, in part, related to cost.

- **Key informant survey of providers of service to homeless individuals:** This, in conjunction with shelter data, will be used to estimate the number of homeless individuals across the state.

- **Include children in study:** The stakeholder group will continue to look for ways to include children within the funds allocated for this study. This will include making estimates based on national statistics.

- **Complete by due date:** The prevalence study is due to the legislature on November 1, 2003.

13. Restrict all RSN fund balances and reserves at maximum of 10 percent of annual revenue **Agency position:** **Concur**	**Accomplishments** • Implemented in FY 02 contract
	Plan
	Obstacles

14. Periodically analyze performance information from RSNs and providers so as to identify and disseminate information on efficient and effective operations and best practices. MHD to create a pool of incentive funds and distribute them as incentives for efficient and effective services. **Agency position:** **Concur**	**Accomplishments** • Performance measure reporting • Benchmark and goals developed • Consumer Outcome System implementation begun • Planning for incentive system begun
	Plan
	Obstacles • Limited RSN support • Limited provider support

ACCOMPLISHMENTS

- **Performance measure reporting:** Measures are being reported in the annual report. The report is widely disseminated to stakeholder groups.

- **Benchmark and goals developed:** Internal MHD workgroup reviewed current performance indicators and developed benchmarks and goals for RSN performance.

- **Consumer Outcome System implementation begun:** When the outcome system is developed and starts generating reliable data, it will be possible to completely implement this recommendation. The system will be partially implemented by June 2003. Anticipated date of complete implementation is January 2004. (See Recommendations 9 and 10)

- **Planning for incentive system begun:** An internal workgroup was developed to create a RSN incentive system tied to performance measures and consumer outcomes.

OBSTACLES

- **Limited RSN support**: RSNs are concerned about what they are accountable for. They are expressing some concern about the outcomes that are being measured.

- **Limited provider support:** Providers are questioning how the system will be useful for them. Continuing experience with the system seems to be reducing some of this concern.

TERMS AND ACRONYMS

ADSA	**Aging and Disability Services Administration, DSHS**
Balanced Budget Act BBA)	**Federal law that increased certain requirements of pre-paid health plans**
CARF	**Council for Accreditation of Rehabilitation Facilities also known as the Rehabilitation Accreditation Commission**
CDMHP	**County Designated Mental Health Professional**
CMS	**Centers for Medicare and Medicaid Services (formerly HCFA)**
CMHS	**The Center for Mental Health Services is a division of the Substance Abuse and Mental Health Services Administration (SAMHSA) of the Federal government.**
DASA	**Division of Alcohol and Substance Abuse, DSHS**
Data Dictionary	**The MHD's published manual of data elements and definitions. RSNs, by contract, are required to report data that is listed in MHD's data dictionary.**
DDD	**Division of Developmental Disabilities, DSHS**
Deeming	**Agreement that certain licensing requirements are met if a provider is accredited by a nationally recognized behavioral health accrediting body.**
DOC	**Department of Corrections**
E&T Center	**Evaluation and Treatment Center – community-based facilities for short term treatment and stabilization of acute episodes of mental illness**
Healthy Options	**A Medicaid managed care plan**
HIPAA	**Health Insurance Portability and Accountability Act**
JCAHO	**Joint Commission for the Accreditation of Healthcare Organizations**
MAA	**Medical Assistance Administration, DSHS**
MHD	**Mental Health Division, DSHS**
Naltrexone	**Opiate antagonist approved by the FDA for treatment of alcohol dependence**
RDA	**Research and Data Analysis, DSHS**
RSN	**Regional Support Network**
TANF	**Temporary Assistance for Needy Families**
WIMIRT	**Washington Institute for Mental Illness Research and Training**